§ 79.24 Proof of initial or first exposure after age 20 for claims under § 79.22(b)(1), or before age 20 for claims under § 79.22(b)(4), or before age 40 for claims under § 79.22(b)(5), or before age 30 for claims under § 79.22(b)(7).

(a) Proof of the claimant's date of birth must be established in accordance with the provisions of subpart B, § 79.14(a).

(b) Absent any indication to the contrary, the earliest date within the designated time period indicated on any records accepted by the Radiation Exposure Compensation Unit as proof of the claimant's physical presence in the affected area will be presumed to be the date of initial or first exposure.

§ 79.25 Proof of onset of leukemia between two and thirty years after first exposure, and proof of onset of a specified compensable disease more than five years after first exposure.

Absent any indication to the contrary, the earliest date within the designated time period indicated on any records accepted by the Radiation Exposure Compensation Unit as proof of the claimant's physical presence in the affected area will be presumed to be the date of first or initial exposure. The date of onset will be the date of diagnosis as indicated in the medical documentation accepted by the Radiation Exposure Compensation Unit as proof of the claimant's specified compensable disease. In the case of leukemia, proof of onset shall be established in accordance with § 79.15.

§ 79.26 Proof of medical condition.

(a) Written medical documentation is required in all cases to prove that the claimant suffered from or suffers from any specified compensable disease. Proof that the claimant contracted a specified compensable disease must be made either by using the procedure outlined in paragraph (b) of this section or submitting the documentation required in paragraph (c) of this section. (For claims arising from a specified compensable disease listed in § 79.27 of these regulations, the claimant or eligible surviving beneficiary must also submit the additional written medical documentation prescribed in that section.)

(b) If a claimant was diagnosed as having one of the specified compensable diseases in the States of Arizona, Colorado, Nevada, New Mexico, Utah or Wyoming, the claimant or eligible surviving beneficiary need not submit any medical documentation of disease at the time the claim is filed (although written medical documentation may subsequently be required). Instead, the claimant or eligible surviving beneficiary must submit with the claim an Authorization To Release Medical and Other Information, valid in the state of diagnosis, that authorizes the Unit to contact the appropriate state cancer or tumor registry. The Unit will accept as proof of medical condition verification from the state cancer or tumor registry that it possesses medical records or abstracts of medical records of the claimant that contain a verified diagnosis of one of the specified compensable diseases. If the designated state does not possess medical records or abstracts of medical records that contain a verified diagnosis of one of the specified compensable diseases, the Unit will notify the claimant or eligible surviving beneficiary and afford that individual the opportunity to submit the written medical documentation required in paragraph (c) of this section, in accordance with the provisions of § 79.52(b).

(c) Proof that the claimant contracted a specified compensable disease may be made by the submission of one or more of the following contemporaneous medical records, provided that the specified document contains an explicit statement of diagnosis and such other information or data from which the appropriate authorities with the National Cancer Institute can make a diagnosis to a reasonable degree of medical certainty. If the medical record submitted does not contain sufficient information or data to make such a diagnosis, the Unit will notify the claimant or eligible surviving beneficiary and afford that individual the opportunity to submit additional medical records identified below, in accordance with the provisions of § 79.52(b). The medical documentation submitted under this section to establish that the

claimant contracted leukemia or a lymphoma must also contain sufficient information from which the appropriate authorities with the National Cancer Institute can determine the type of leukemia or lymphoma contracted by the claimant. Proof of leukemia shall be made by submitting one or more of the documents listed in § 79.16(c).

(1) *Multiple myeloma.* (i) Pathology report of tissue biopsy;

(ii) Autopsy report;

(iii) Report of serum electrophoresis;

(iv) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Hematology summary or consultation report;

(D) Oncology summary or consultation report;

(E) X-ray report;

(v) Death certificate, provided that it is signed by a physician at the time of death.

(2) *Lymphomas.* (i) Pathology report of tissue biopsy;

(ii) Autopsy report;

(iii) One of the following summary medical report:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Hematology consultation or summary report;

(D) Oncology consultation or summary report;

(iv) Death certificate, provided that it is signed by a physician at the time of death.

(3) *Cancer of the thyroid.* (i) Pathology report of tissue biopsy or fine needle aspirate;

(ii) Autopsy report;

(iii) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary;

(C) Operative summary report;

(D) Oncology summary or consultation report;

(iv) Death certificate, provided that it is signed by a physician at the time of death.

(4) *Cancer of the female breast.* (i) Pathology report of tissue biopsy or surgical resection;

(ii) Autopsy report;

(iii) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary;

(C) Operative report;

(D) Oncology summary or consultation report;

(E) Radiotherapy summary or consultation report;

(iv) Report of mammogram;

(v) Report of bone scan;

(vi) Death certificate, provided that it is signed by a physician at the time of death.

(5) *Cancer of the esophagus.* (i) Pathology report of tissue biopsy or surgical resection;

(ii) Autopsy report;

(iii) Endoscopy report;

(iv) One of the following summary medical report:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Operative report;

(D) Radiotherapy report;

(E) Oncology consultation or summary report;

(v) One of the following radiological studies:

(A) Esophagram;

(B) Barium swallow;

(C) Upper gastrointestinal (GI) series;

(D) Computerized tomography (CT) scan;

(E) Magnetic resonance imaging (MRI);

(vi) Death certificate, provided that it is signed by a physician at the time of death.

(6) *Cancer of the stomach.* (i) Pathology report of tissue biopsy or surgical resection;

(ii) Autopsy report;

(iii) Endoscopy or gastroscopy report;

(iv) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Operative report;

(D) Radiotherapy report;

(E) Oncology summary report;

(v) One of the following radiological studies:

(A) Barium swallow;

(B) Upper gastrointestinal (GI) series;

(C) Computerized tomography (CT) series;

(D) Magnetic resonance imaging (MRI);

(vi) Death certificate, provided that it is signed by a physician at the time of death.

(7) *Cancer of the pharynx.* (i) Pathology report of tissue biopsy or surgical resection;

(ii) Autopsy report;

(iii) Endoscopy report;

(iv) One of the following summary medical reports:

(A) Physician summary;

(B) Hospital discharge summary;

(C) Report of otolaryngology examination;

(D) Radiotherapy summary report;

(E) Oncology summary report;

(F) Operative report;

(v) Report of one of the following radiological studies:

(A) Laryngograms;

(B) Tomograms of soft tissue and lateral radiographs;

(C) Computerized tomography (CT) scan;

(D) Magnetic resonance imaging (MRI);

(vi) Death certificate, provided that it is signed by a physician at the time of death.

(8) *Cancer of the small intestine.* (i) Pathology report of tissue biopsy;

(ii) Autopsy report;

(iii) Endoscopy report, provided the examination covered the duodenum and parts of the jejunum;

(iv) Colonoscopy report, providing the examination covered the distal ileum;

(v) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary;

(C) Report of gastroenterology examination;

(D) Operative report;

(E) Radiotherapy summary report;

(F) Oncology summary or consultation report;

(vi) Report of one of the following radiologic studies:

(A) Upper gastrointestinal (GI) series with small bowel followthrough;

(B) Angiography;

(C) Computerized tomography (CT) scan;

(D) Magnetic resonance imaging (MRI);

(vii) Death certificate, provided that it is signed by a physician at the time of death.

(9) *Cancer of the pancreas.* (i) Pathology report of tissue biopsy or fine needle aspirate;

(ii) Autopsy report;

(iii) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Radiotherapy summary report;

(D) Oncology summary report;

(iv) Report of one of the following radiographic studies:

(A) Endoscopic retrograde cholangiopancreatography (ERCP);

(B) Upper gastrointestinal (GI) series;

(C) Arteriography of the pancreas;

(D) Ultrasonography;

(E) Computerized tomography (CT) scan;

(F) Magnetic resonance imaging (MRI);

(v) Death certificate, provided that it is signed by a physician at the time of death.

(10) *Cancer of the bile duct.* (i) Pathology of tissue biopsy or surgical resection;

(ii) Autopsy report;

(iii) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Operative report;

(D) Gastroenterology consultation report;

(E) Oncology summary or consultation report;

(iv) Report of one of the following radiographic studies:

(A) Ultrasonography;

(B) Endoscopic retrograde cholangiography;

(C) Percutaneous cholangiography;

(D) Computerized tomography (CT) scan;

(v) Death certificate, provided that it is signed by a physician at the time of death.

(11) *Cancer of the gall bladder.* (i) Pathology report of tissue from surgical resection;

(ii) Autopsy report;

(iii) Report of one of the following radiological studies:

(A) Computerized tomography (CT) scan;

(B) Magnetic resonance imaging (MRI);

(C) Ultrasonography (ultrasound);

(iv) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Operative report;

(D) Radiotherapy report;

(E) Oncology summary or report;

(v) Death certificate, provided that it is signed by a physician at the time of death.

(12) *Cancer of the liver.* (i) Pathology report of tissue biopsy or surgical resection;

(ii) Autopsy report;

(iii) One of the following summary medical reports:

(A) Physician summary report;

(B) Hospital discharge summary report;

(C) Oncology summary report;

(D) Operative report;

(E) Gastroenterology report;

(iv) Report of one of the following radiological studies:

(A) Computerized tomography (CT) scan;

(B) Magnetic resonance imaging (MRI);

(v) Death certificate, provided that it is signed by a physician at the time of death.

§79.27 Proof of no heavy smoking, no heavy drinking, no heavy coffee drinking and no indication of the presence of hepatitis B and cirrhosis.

(a)(1) If the claimant or eligible surviving beneficiary is claiming eligibility under this subpart for primary cancer of the esophagus, pharynx, pancreas, or liver, the claimant or eligible surviving beneficiary must submit, in addition to proof of the disease, all medical records listed below from any hospital, medical facility, or health care provider that were created within the period six (6) months before and six (6) months after the date of diagnosis of primary cancer of the esophagus, pharynx, pancreas, or liver:

(i) All history and physical examination reports;

(ii) All operative and consultation reports;

(iii) All pathology reports; and

(iv) All physician, hospital, and health care facility admission and discharge summaries.

(2) In the event that any of the records in paragraph (a)(1) of this section no longer exist, the claimant or eligible surviving beneficiary must submit a certified statement by the custodian(s) of those records to that effect.

(b) If the medical records listed in paragraph (a) of this section, or information possessed by the state cancer or tumor registries, reflects that the claimant was a heavy smoker or a heavy drinker or indicates the presence of hepatitis B and/or cirrhosis, the Radiation Exposure Compensation Unit will notify the claimant or eligible surviving beneficiary and afford that individual the opportunity to submit other written medical documentation or contemporaneous records in accordance with §79.52(b) to establish that the claimant was not a heavy smoker or heavy drinker or that there was no indication of hepatitis B and/or cirrhosis.

(c) The Program may also require that the claimant or eligible surviving beneficiary provide additional medical records or other contemporaneous records and/or an authorization to release such additional medical and contemporaneous records as may be needed to make a determination regarding the indication of the presence of hepatitis B and/or cirrhosis and the claimant's history of smoking and alcohol consumption.

(d) If the custodian(s) of the records listed in paragraph (a) of this section and the records requested in accordance with paragraph (c) of this section certifies that a claimant's records no longer exist, and if the state cancer or tumor registries do not contain information concerning the claimant's history of smoking or alcohol-consumption, the Assistant Director may require that the claimant or eligible surviving beneficiary submit an affidavit (or declaration) made under penalty of perjury detailing the histories or lack thereof and, if the affiant (or declarant) is the eligible surviving beneficiary, the basis for such knowledge. This affidavit (or declaration) will be